

ADULT
MEDICAL RELEASE AND INFORMATION FORM
(Medical Information for Overnight Trips/Retreats Only)

Name of participant _____ DOB _____

Medication presently on (Name and dosage for each)

Allergies (Foods, Medication, etc.):

Any other Medical conditions (asthma, diabetes, seizures etc.)

Date of last tetanus shot _____

Contact Person: (relationship) Home Phone Work Phone Cell Phone

Contact Person (alternate) Home Phone Work Phone Cell Phone

I hereby give my permission to be administered medical help in case of an emergency. If you have medical insurance please indicate the following:

Insurance Company: _____ Phone: _____

Policy Name: _____ Policy Number: _____

Family Doctor: _____ Doctor's Phone Number: _____

Signature _____ Date: ___ / ___ / _____

Sworn To and subscribed before me on this _____ day of _____ 20_____

My commission expires: _____

Notary Public (seal)